

Manchester Post Basic Dysphagia Course

Supervisor's Report

Student name:

Student Number:

Supervisor's name:

Supervisor's email address:

Supervisor's daytime telephone number:

Supervisor's correspondence address:

I confirm that the student named above has completed 40 hours of dysphagia patient-centred clinical work.

Supervisor's signature:

Date:

I confirm that the student named above has completed 32 hours dysphagia-related, but not patient-specific, activity (i.e. reading, courses, meetings).

Supervisor's signature:

Date:

Is the student named above competent to practice unsupervised with their designated dysphagia caseload?

YES NO (please circle the correct answer and strike through the incorrect answer)

Supervisor's signature:

Date:

Comments (optional):